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Ensuring Diversity in the Health Care Workforce (2004)

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Ensuring Diversity in the Health Care Workforce

Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Health Care Workforce

Board on Health Sciences Policy

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Executive Summary

Health Care's Compelling Interest: Ensuring Diversity In Its Workforce

ABSTRACT

The United States is rapidly becoming a more diverse nation, as demonstrated by the fact that non-white racial and ethnic groups will constitute a majority of the American population later in this century. The representation of many of these groups (e.g., African Americans, Hispanics, and Native Americans) within health professions, however, is far below their representation in the general population. Increasing racial and ethnic diversity among health professionals is important because evidence indicates that diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health professions students, among many other benefits.

Many groups—including health professions educational institutions (HPEIs), private foundations, and state and federal government agencies—have worked to increase the preparation and motivation of underrepresented minority (URM) students to enter health professions careers. Less attention, however, has been focused on strategies to reduce institutional- and policy-level barriers to URM participation in health professions training.

HPEIs can improve admissions policies and reduce barriers to URM admission by developing a clear statement of mission that recognizes the value of diversity in health professions education. Admissions policies should be based on a comprehensive review of each applicant, including an assessment of applicants' attributes that best support the mission of the institution (e.g., background, experience, multi-lingual abilities). Admissions models should balance quantitative data (i.e., prior grades and standardized test scores) with these qualitative characteristics.

The federal Health Resources and Services Administration (HRSA) is a major funder of health professions training that seeks to improve the quality and availability of diverse health professionals through an array of programs. These health professions programs should be evaluated to assess their effectiveness in increasing the numbers of URM students enrolling and graduating from HPEIs, and Congress should provide increased funding for programs shown to be effective in enhancing diversity. State and local entities should increase support for diversity efforts through programs such as loan forgiveness, tuition reimbursement, loan repayment, and other efforts. In addition, private entities should be encouraged to collaborate through business partnerships with HPEIs to support the goal of developing a more diverse health-care workforce.

The U.S. Department of Education should strongly encourage accreditation bodies to be more aggressive in formulating and enforcing standards that result in a critical mass of URMs throughout the health professions. In addition, health professions education accreditation bodies

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should develop explicit policies articulating the value and importance of diversity among health professionals, and monitor the progress of member institutions toward achieving these goals.

HPEIs should develop and regularly evaluate comprehensive strategies to improve the institutional climate for diversity. As part of this process, HPEIs should proactively and regularly engage and train students, house staff, and faculty regarding institutional diversity-related policies and expectations and the importance of diversity to the long-term institutional mission.

HPEI governing bodies should develop institutional objectives consistent with community benefit principles that support the goal of increasing health-care workforce diversity, including efforts to ease financial and non-financial obstacles to URM participation, increase involvement of diverse local stakeholders in key decision-making processes, and undertake initiatives that are responsive to local, regional and societal imperatives. These objectives are best assessed and enforced via the accreditation process.

EXECUTIVE SUMMARY

In a landmark decision that resolved over five years of litigation—and an even longer period of contentious national debate—the U.S. Supreme Court ruled in *Grutter v. Bollenger* that the University of Michigan Law School's consideration of race and ethnicity as one of many factors in the admissions process was lawful, because the practice was "narrowly tailored" and did not violate the constitutional rights of non-minority applicants. Perhaps more importantly, the Court declared that the university's position that achieving a "critical mass" of racial and ethnic diversity in its law school was a compelling interest of the law school and the nation, a rationale that will have far-reaching implications, not just for underrepresented minority (URM) students[1] but also for the nation as a whole.

Few professional fields will feel the impact of the decision in the *Grutter* case—and the potential influence of greater levels of racial and ethnic diversity—as profoundly as the health professions. Health professions disciplines are grappling with the impact of major demographic changes in the United States population, including a rapid increase in the proportions of Americans who are non-white, who speak primary languages other than English, and who hold a diverse range of cultural values and beliefs regarding health and health care. Efforts to increase the proportions of underrepresented minorities in health professions fields, however, have met with limited success. To a great extent, efforts to diversify health professions fields have been hampered by gross inequalities in educational opportunity for students of different racial and ethnic groups. Primary and secondary education for URM students is, on average, far below the quality of education for non-URM students. The "supply" of URM students who are well-prepared for higher education and advanced study in health professions fields has therefore suffered.

Equally important, however, are efforts to reduce policy-level barriers to URM participation in health professions training, and to increase the institutional "demand" for URM students. For example, several events—including public referenda (i.e., the California Civil Rights Initiative [Proposition 209] and Initiative 200 in Washington state), judicial decisions (e.g., the Fifth

[1] For purposes of this report, the study committee defines "underrepresented minorities" as those racial and ethnic groups that are underrepresented in the heath professions relative to their numbers in the general population. This definition allows individual institutions to define which populations are underrepresented in its area of interest. The definition is consistent with the definition of "underrepresented minorities in medicine" recently adopted by the Association of American Medical Colleges (AAMC); previously, AAMC's definition was been limited to historically disadvantaged groups (e.g., African Americans, some Hispanic/Latino groups, and Native Americans). The new definition takes into account the fact that many other groups, such as subpopulations of Asian Americans, Pacific Islanders, and Latinos, are also poorly represented among health professionals, and many in these communities face barriers to accessing appropriate health care.

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District Court of Appeals finding in *Hopwood v. Texas*) and lawsuits challenging affirmative action policies in 1995, 1996, and 1997—forced many higher education institutions to abandon the use of race and ethnicity as factors in admissions decisions (in some cases temporarily, in light of the Supreme Court decision in *Grutter*), and to curtail race- and ethnicity-based financial aid.

Given these problems—an increasing need for underrepresented minority health professionals, policy challenges to affirmative action, and little progress toward enhancing the numbers of URM students prepared to enter health professions careers—the W.K. Kellogg Foundation requested a study by the Institute of Medicine (IOM) to assess institutional and policy-level strategies for achieving greater diversity among health-care professionals. Specifically, the IOM was asked to:

- assess and describe potential benefits of greater racial and ethnic diversity among health professionals;
- assess institutional and policy-level strategies that may increase diversity within the health professions, including:
  - modifying HPEIs' admissions practices,
  - reducing financial barriers to health professions training among minority and lower-income students,
  - increasing the emphasis on diversity goals in HPEI program accreditation,
  - improving the HPEI campus "climate" for diversity, and
  - considering the application of community benefit principles to improve the accountability of non-profit, tax exempt institutions (e.g., medical schools and teaching hospitals) to the diverse racial and ethnic communities they serve; and,
- identify mechanisms to garner broad support among health professions leaders, community members, and other key stakeholders to implement these strategies.

This Executive Summary presents a shortened version of the study committee's full report, with summaries of the analysis, findings, and recommendations.[2] The reader is referred to the full report for a more detailed discussion of the committee's findings and recommendations.

Why is Racial and Ethnic Diversity Important in Health Professions Fields?

A preponderance of scientific evidence supports the importance of increasing racial and ethnic diversity among health professionals. This evidence (some of which is summarized below) demonstrates that greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, better patient–provider communication, and better educational experiences for *all* students while in training.

Racial and Ethnic Diversity among Health Professionals and Access to Health Care for Minority Patients

Racial and ethnic minority health care professionals are significantly more likely than their white peers to serve minority and medically underserved communities, thereby helping to improve problems of limited minority access to care. For example, URM physicians are more

[2] Recommendations in this Executive Summary are presented in the order in which they appear and as they are designated in the full report. Enumeration is based on the chapter in which the recommendations are presented. Enumeration begins with recommendations presented in Chapter 2, which are designated as 2-1, 2-2, and so on.

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likely to treat patients of color (Komaromy et al, 1996), indigent patients, and patients that are sicker (Moy and Bartman, 1995; Cantor et al., 1996) than non-URM physicians. Racial and ethnic minority dentists (Solomon et al., 2001) and psychologists (Turner and Turner, 1996) are also more likely than their white peers to practice in racial and ethnic minority communities.

Diversity and Minority Patient Choice and Satisfaction

Minority patients who have a choice are more likely to select health-care professionals of their own racial or ethnic background (Saha et al., 2000; LaVeist and Nuru-Jeter, 2002). Moreover, racial and ethnic minority patients are generally more satisfied with the care that they receive from minority professionals (Saha et al., 1999; LaVeist and Nuru-Jeter, 2002), and minority patients' ratings of the quality of their health care are generally higher in racially concordant than in racially discordant settings (Cooper-Patrick et al., 1999).

Diversity and Quality of Training for Health Professionals

Diversity in health professions training settings may assist in efforts to improve the cross-cultural training and cultural competencies of *all* trainees. Interaction among students from diverse backgrounds in training settings may help students to challenge assumptions and broaden perspectives regarding racial, ethnic, and cultural differences (Cohen, 2003; Whitla et al., 2003). In addition, there is growing evidence, primarily from studies of college students' undergraduate experiences, that campus diversity experiences are associated with gains in *all* students' learning outcomes and community involvement (e.g., Gurin et al., 2002; Antonio et al., in press; Whitla et al., 2003).

Despite the importance of diversity in health professions, African Americans, American Indians and Alaska Natives, many Hispanic/Latino populations, and some Asian American (e.g., Hmong and other Southeast Asians) and Pacific Islander groups (e.g., Native Hawaiians) are grossly underrepresented among the nation's health professionals. A range of institutional and policy-level strategies to increase the presence of URMs in the health professions are discussed below.

Reconceptualizing Admissions Policies and Practices

Although admissions practices vary by institution and discipline, admission into many HPEIs remains a highly competitive process, in which many talented applicants compete for a limited number of slots. For a range of reasons, including efficiency in sorting through a large number of applicants, and to attain a reasonable expectation of how applicants can be expected to perform in HPEIs, many admissions committees rely heavily on quantitative information, such as applicants' prior grades and standardized test scores, in identifying those applicants that will receive serious consideration.

Standardized test scores are generally good predictors of subsequent academic performance, but have been used—in some cases inappropriately—as a barometer of applicants' academic "merit," often to the detriment of URM students. Some higher education institutions, as well as many among the general public, cling to the belief that admissions tests measure a "compelling distillation of academic merit" (National Research Council, 1999). Yet standardized admissions tests do not measure the full range of abilities that are needed to succeed in higher education (Sternberg and Williams, 1997), nor were they designed to. In addition, test scores are malleable, and are not indicative of fine distinctions between individual applicants. Admissions

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tests, whether they measure aptitude or achievement, are therefore best viewed as imprecise estimates of how students might be expected to perform in specific educational contexts, and are best used to sort applicants into broad categories (National Research Council, 1999).

URM students typically score lower than their white or Asian American peers on a range of standardized tests, including the SAT, GRE, and MCAT. This disparity occurs for a variety of reasons, but principally because of poorer educational opportunities afforded to African American, Latino, and American Indian/Alaska Native students. These students are more likely than non-URM students to attend schools that are racially and economically segregated, poorly funded, offer few (if any) advanced placement and college preparatory classes, have fewer credentialed teachers, and suffer from a climate of low expectations (American Sociological Association, 2003; Camara and Schmidt, 1999). Moreover, even among those URM students who are invested in high academic performance, social and psychological factors—such as the pressure to perform above levels suggested by stereotypes of low minority academic ability—may serve to suppress their test performance (Steele, 1997; Steele and Aronson, 1995).

When quantitative variables such as standardized test scores are weighted heavily in the admissions process, URM applicants, because of their generally poorer academic preparation and test performance, are less successful in gaining admission than non-URM applicants. Absent admissions practices that allow applicants' race or ethnicity to be considered along with other personal characteristics of applicants, URM student participation in health professions education is likely to decline sharply. States that have implemented "percent solution" admissions strategies (i.e., where a top percentage of high school graduates are guaranteed admission to the state university system) have found that URM admissions have generally not increased (Tienda et al., 2003; Horn and Flores, 2003; Marin and Lee, 2003). In addition, an analysis by the Association of American Medical Colleges of the likely impact of "race-neutral" admissions policies in medical schools reveals that 70 percent fewer URM students would gain admission under such conditions (Cohen, 2003).

These barriers to URM admission have led some HPEIs to reconceptualize their admissions policies and practices to place greater weight on applicants' qualitative attributes, such as leadership, commitment to service, community orientation, experience with diverse groups, and other factors. This shift of emphasis to professional and "humanistic" factors is also consistent with a growing recognition in health professions fields that these attributes must receive greater attention in the admissions process to maintain professional quality, to ensure that future health professionals are prepared to address societal needs, and to maintain the public's trust in the integrity and skill of health professionals (Edwards et al. 2001). Anecdotally, evidence suggests that this shift may also reduce barriers to admission of qualified URM applicants, thereby achieving the dual goals of improving both the quality and diversity of health professions students (Garcia et al., 2003; Maldonado, 2001). Several HPEIs have adopted admissions policies that:

- Encourage admissions procedures to closely follow the institutions' stated mission with regard to teaching, research, and service—particularly if the needs of medically underserved communities are a part of the institutional mission;
- Encourage a comprehensive review of applicants' files, to understand how students' personal, community, and professional backgrounds may influence students' prior academic performance and contribute to the learning environment;
- Require admissions committee members to receive training aimed at improving their ability to assess underrepresented applicants, and sharpening interviewing skills;

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- De-emphasize standardized test data in the admissions equation, after a diverse group of academically qualified candidates are identified; and
- Include representatives from groups affected by the institution's admissions decisions on admissions committees, and increase incentives for faculty participation on admissions committees.

Recommendation 2-1: HPEIs[3] should develop, disseminate, and utilize a clear statement of mission that recognizes the value of diversity in enhancing its mission and that of the relevant health-care professions.

Recommendation 2-2: HPEIs should establish explicit policies regarding the value and importance the institution places on the teaching and provision of culturally competent care, and the role of institutional diversity in achieving this goal.

Recommendation 2-3: Admissions should be based on a comprehensive review of each applicant, including an assessment of applicants' attributes that best support the mission of the institution (e.g., race/ethnicity, background, experience, multi-lingual abilities). Admissions models should balance quantitative data (i.e., prior grades and standardized test scores) with these qualitative characteristics.

Recommendation 2-4: Admissions committees should include voting representation from underrepresented groups. In addition, HPEIs should provide special incentives to faculty for participation on admissions committees (e.g., by providing additional weight or consideration for service during promotion review), and provide training for committee members on the importance of diversity efforts and means to improve diversity within the committee purview.

Reducing Financial Barriers to URM Participation in Health Professions Education

The costs associated with health professions training pose a significant barrier for many URM students, whose economic resources are lower, on average, than non-URM students. In recent years, financial barriers to both undergraduate and graduate education have risen sharply due to shifts in policies and priorities at the federal, state, and institutional levels. Tuition and other educational costs have climbed steadily, while at the same time sources of grant aid have decreased (Advisory Committee on Student Financial Assistance, 2002). The trends toward increased tuition costs and deceased need-based aid have resulted in higher levels of unmet need for lower-income students. The impact of high unmet need can be considerable on low-income students, even those who are academically prepared for the challenges of higher education. Low-income students with high unmet need are significantly less likely to expect to finish college; plan to attend a 4-year college after graduating from high school; take entrance exams; and apply, enroll, and persist to degree completion than high-income students with low unmet need (Advisory Committee on Student Financial Assistance, 2002; The College Board, 2003; U.S. Department of Education, 2003).

Student financial assistance for health professions education is provided by a number of federal, state, and private sources. At the federal level, the Health Resources and Services Ad-

[3] Recommendations regarding admissions policies and practices are intended to apply to health professions educational institutions, whether free-standing or affiliated with a university or embedded in another institution.

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ministration (HRSA) is the primary funder for health professions programs that either target or in some way include URM students, practitioners, and/or faculty. HRSA is charged with administering Title VII and Title VIII of the Public Health Service Act. These titles authorize funding, through a variety of programs for students and institutions, in order to increase the quality of the education and training of the primary care provider workforce, with special attention to the geographic, racial, and ethnic diversity of the United States health-care workforce. Title VII applies to medicine and dentistry (and in many cases mental health), while Title VIII pertains to nursing. These programs have provided support for many URM health professions students, yet Congressional appropriations for these programs have fluctuated as a result of budget pressures.

Among private sources of funding for URM health professions students, several organizations have contributed significantly toward scholarships, loan repayment, and stipend programs, in addition to mentoring and other support programs to enhance URM representation in health professions. These include the National Medical Fellowships, The California Endowment, the California Wellness Foundation, the W.K. Kellogg Foundation, the Ford Foundation, and the Robert Wood Johnson Foundation.

The large variety and scope of public and private efforts for funding URMs in health profession education make it difficult to assess if and how well these programs work together and complement one another in their efforts. While there are many programs targeting URM students who are entering graduate education, many of these same programs, as well as a host of others, also engage in pipeline efforts. The result is "a discontinuity of interventions across regions and across stages of the educational pipeline, making it difficult to sustain gains from one educational stage to the next" (Grumbach et al., 2002). Coordination and communication among various programs will help allow programs to better plan their own efforts and determine additional needs.

Recommendation 3-1: HRSA's health professions programs should be evaluated to assess their effectiveness in increasing the numbers of URM students enrolling and graduating from HPEIs to ensure that they maximize URM participation.

Recommendation 3-2: Congress should increase funding for Public Health Service Act Titles VII and VIII programs shown to be effective in increasing diversity, and should develop other financial mechanisms to enhance the diversity of the health-care workforce.

Some public and private entities have developed innovative collaborations to provide student financial support and institutional diversity efforts in ways that may increase the number of URM students in health professions programs. For example, the University of Colorado Health Sciences School of Dentistry has partnered with the Orthodontic Education Company (OEC) to establish a new dental center that they hope will address the shortage of orthodontists, provide low-cost care to children in underserved areas, and attract individuals from these communities to dental careers. The OEC provides scholarships and stipends in exchange for service in OEC private or group practices following graduation. The University of Colorado will establish and administer the program, supported by an investment of almost $100 million by the OEC. In other efforts, New York State has initiated the Minority Participation in Medical Education Grant Program, which provides funds to institutions to enhance minority recruitment and retention, develop minority student mentoring programs, develop medical career pathways for minority students, and develop minority faculty role models. A second program initiated by the state,

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the Graduate Medical Education (GME) Reform Incentive Pool, seeks to increase the representation of minorities in graduate medical education, increase the number of residents in primary care, and promote practice in underserved areas, among other goals. The program provides funds to hospitals and groups of training institutions.

Recommendation 3-3: State and local entities, working where appropriate with HPEIs, should increase support for diversity efforts through programs such as loan forgiveness, tuition reimbursement, loan repayment, Medicaid GME, and supportive affiliations with community-based providers.

Recommendation 3-4: Private entities should be encouraged to collaborate through business partnerships and other entrepreneurial relationships with HPEIs to support the common goal of developing a more diverse health-care workforce.

Accreditation as a Key to Increase Diversity in Health Professions

Accreditation is the process by which non-governmental organizations set standards for and monitor the quality of educational programs provided by member institutions. Accreditation is a voluntary process of institutional self-regulation, often conducted within the broad framework of standards established by the U.S. Department of Education and the Council for Higher Education Accreditation (CHEA). By setting standards for educational programs and methods for institutional peer review, accrediting bodies advance academic quality, ensure accountability to the public, encourage institutional progress and improvement, and provide a mechanism for continual assessment of broad educational goals for higher education. As such, accreditation is an important vehicle for institutional change, and a potential means to enhance diversity in health professions.

The increasing diversity of the United States population requires that accreditation bodies be responsive to demographic changes, and develop and enforce standards that ensure that health professionals are prepared to serve diverse segments of the population. As one accreditation official noted during a public workshop hosted by the study committee, "Our role is to serve the public." Given that almost all accreditation bodies view public service and accountability as central to their mission, establishing and monitoring goals related to diversity among health-care professions can be unambiguously viewed as an important aspect of this effort.

Accreditation bodies may take varying approaches in efforts to accomplish these goals. The standards and practices adopted by the American Psychological Association (APA), however, are instructive and offer several approaches for accreditation standards to address diversity concerns (APA Committee on Accreditation, 2002):

1. Develop a plan to achieve diversity, consistent with the institutional mission, and demonstrate efforts to reach diversity goals.
2. Develop standards that encourage the development and infusion of diversity-related curricula throughout the training program.
3. Regularly monitor and evaluate the efforts of accredited institutions in achieving their diversity goals.
4. Graduated sanctions and reinforcement from the accrediting body can help to "shape" appropriate diversity efforts.
5. Seek community representation on standard-setting bodies.

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6. Seek diverse representation on peer review teams.

APA's accreditation standards have contributed to an increased level of attention and effort among psychology education and training institutions in addressing diversity concerns (Zlotlow, 2003). Some of these programs, for example, have developed new websites devoted to promoting and enhancing diversity-related institutional policies and curriculums, and accreditation standards have promoted greater sharing among training programs regarding strategies to improve minority recruitment and retention efforts (Zlotlow, 2003).

Recommendation 4-1: The U.S. Department of Education should strongly encourage accreditation bodies to be more aggressive in formulating and enforcing standards that result in a critical mass of URMs throughout the health professions.

Recommendations 4-2: Health professions education accreditation bodies should develop explicit policies articulating the value and importance of providing culturally competent health care, and the role it sees for racial and ethnic diversity among health professionals in achieving this goal.

Recommendation 4-3: Health professions education accreditation bodies should develop standards and criteria that more effectively encourage health professions schools to recruit URM students and faculty, to develop cultural competence curricula, and to develop an institutional climate that encourages and sustains the development of a critical mass of diversity.

Recommendation 4-4: Accreditation standards should include criteria to assess the number and percentage of URM candidates, students admitted and graduated, time to degree, and number and level of faculty.

Recommendation 4-5: Accreditation advisory boards and accreditation bodies should include URMs and other individuals with expertise in diversity and cultural competence.

Recommendation 4-6: If diversity-related standards are not met, the institution should be required to declare formally what steps will be put in place to address the deficiencies. Repeated deficiencies should result in accreditation-related sanctions.

Transforming the Institutional Climate to Enhance Diversity

The institutional climate for diversity—defined as the perceptions, attitudes, and values that define the institution, particularly as seen from the perspectives of individuals of different racial or ethnic backgrounds—can exert a profound influence on diversity efforts. Diversity is most often viewed as the proportion and number of individuals from groups underrepresented among students, faculty, administrators, and staff (i.e., structural diversity). Diversity, however, can also be conceptualized as the *diversity of interactions* that take place on campus (e.g., the quality and quantity of interactions across diverse groups, and the exchange of diverse ideas), as well as *campus diversity-related initiatives and pedagogy* (e.g., the range and quality of curricula and programming pertaining to diversity, such as cultural activities and cultural awareness work-

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shops; Hurtado et al., 1999). Each of these elements of diversity must be carefully considered as institutions assess their diversity goals.

The institutional climate for diversity is influenced by several elements of the institutional context, including the degree of structural diversity, the historical legacy of inclusion or exclusion of students and faculty of color, the psychological climate (i.e., perceptions of the degree of racial tension and discrimination on campus), and the behavioral dimension (i.e., the quality and quantity of interactions across diverse groups and diversity-related pedagogy; Hurtado et al., 1999). Each of the dimensions of the institutional climate may influence diversity efforts, in both positive and negative ways. More importantly, the institutional climate is malleable and can be altered through interventions aimed at each of element of the institutional context.

How Can Health Professions Education Institutions Enhance the Institutional Climate for Diversity?

Building on this research and theory, Hurtado et al. (1999) outline twelve strategies for helping institutions to achieve an improved climate for diversity and to maximize the benefits of diversity. The first four principles (i.e., affirm the value of diversity, systematically assess the climate, develop a plan of action, and institute on-going evaluation of the plan) are "core" to any institutional efforts for change, while the remaining eight offer guidance for the development of new programs and policies. Hurtado and colleagues stress that these principles represent a comprehensive, "holistic" approach to institutional change and require that institutions possess strong leadership, adequate resources to support change efforts, strong planning and evaluation, and a long-term commitment to diversity goals.

Recruitment, Hiring, and Retention of Underrepresented Minority Faculty

Enhancing the racial and ethnic diversity of health professions education faculty can provide support for URM students in the form of role models and mentors, lead to important pedagogical changes, and "bring new kinds of scholarship to an institution, educate students on issues of growing importance to society, and offer links to communities not often connected to our campuses" (Smith, 2000, p. 51). HPEIs can take several steps to improve their efforts to recruit minority faculty. To begin, institutions should carefully examine their mission statement and assess how faculty diversity assists the institution to meet its goals. Identifying and recruiting qualified URM faculty candidates can be improved by utilizing active search processes that go beyond simply posting positions and recruiting though networks that are familiar to the faculty. Search committees should be diverse, to help in assessing and evaluating candidates of different backgrounds, and should have a close working relationship with the university administration to ensure the success of the search process. Finally, post-hiring support is critical for many URM faculty members to address the challenges of earning tenure, balancing teaching and research, and other faculty concerns (Smith, 2000).

Minority Student Recruitment and Retention

Several HPEIs have implemented successful URM student recruitment and retention programs. Some elements of successful recruitment efforts include developing academic and educational partnerships with minority-serving institutions, addressing financial barriers, targeting outreach to URM students, and engaging pre-health advisors. As significantly, institutions should develop comprehensive strategies to retain URM students, by instituting a range of academic and social supports, including faculty and peer mentoring, tutoring and academic skills assessment,

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and teaching study skills. Institutions may increase opportunities for URM students to integrate themselves into the campus community (and take advantage of support programs) through both ethnic- and racial-group interest organizations, as well as general campus programs, such as orientation programs that clearly outline the institutions' expectations regarding diversity-related policies and goals, and sensitivity training programs that increase awareness and understanding of diversity in the campus context. A confidential ombudsman program may assist efforts to improve the campus climate for diversity by providing an informal mediation process to gather information about complaints, advise individuals about how to resolve disputes informally, mediate disputes, seek "win–win" resolution of problems, and advise individuals about more formal grievance procedures should informal efforts fail (Steinhardt and Connell, 2002).

Recommendation 5-1: HPEIs should develop and regularly evaluate comprehensive strategies to improve the institutional climate for diversity. These strategies should attend not only to the structural dimensions of diversity, but also to the range of other dimensions (e.g., psychological and behavioral) that affect the success of institutional diversity efforts.

Recommendation 5-2: HPEIs should proactively and regularly engage and train students, house staff, and faculty regarding institutional diversity-related policies and expectations, the principles that underlie these policies, and the importance of diversity to the long-term institutional mission. Faculty should be able to demonstrate specific progress toward achieving institutional diversity goals as part of the promotion and merit process.

Recommendation 5-3: HPEIs should establish an informal, confidential mediation process for students and faculty who experience barriers to institutional diversity goals (e.g., experiences of discrimination, harassment).

Recommendation 5-4: HPEIs should be encouraged to affiliate with community-based health-care facilities in order to attract and train a more diverse and culturally competent workforce and to increase access to health care.

Community Benefit Principles and Diversity

Community benefit is a legal term that applies to charitable activities that benefit the community as a whole. For over 100 years, federal tax law has recognized the significant role of charitable trusts (nonprofits that serve "religious, charitable, scientific, literary, or educational purposes) in furthering governmental and social goals, providing for income tax exemption for qualifying organizations. The framework of charitable trust has been adopted and maintained in every update of the tax code since the original ruling. Historically, this framework has expanded beyond early "relief of poverty" criteria for hospitals to qualify for tax exemption as 501(c)(3) nonprofit organizations, to more recent IRS rulings that removed the requirement to provide services for the poor, and identified the promotion of health (i.e., community benefit) as a charitable purpose.

Since then, some states have established formal guidelines for nonprofit hospitals and nursing homes. States such as New York have required the development and implementation of "community service plans" by nonprofit hospitals. Requirements include an annual review of the hospital mission statement, publication of hospital assets and liabilities, an assessment of community needs and hospital strategies to address them, and the solicitation of input from commu-

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nity stakeholders. The Utah State Tax Commission issued a set of formal guidelines for nonprofit hospitals and nursing homes that included a requirement for a minimum financial threshold of contributions that exceed the annual property tax liability of each facility. The legal requirements New York and Utah placed upon nonprofit health-care providers reflect two alternative approaches that have marked subsequent state actions in this arena: a general reporting requirement (NY) and the establishment of a minimum financial threshold (UT).

Between 1990 and 2001, a total of eleven states implemented some form of legal mechanism to increase the accountability of nonprofit health-care providers. Eight of the eleven took the general reporting requirement approach; three took the minimum financial threshold approach. In addition, states are requiring such activities as:

- community assessments to identify local unmet needs,
- solicitation of community input in the development of community benefit plans, and
- review of organizational mission statements to reflect a commitment to address community health needs.

These efforts have yielded mixed results, primarily because of inconsistencies in the application of community benefit regulations and inadequate administrative resources for states to provide oversight regarding compliance. States with reporting requirements, for example, find that there are numerous examples of promising programs, but substantial variability in the quality and specificity of reporting make it impossible to conduct a reliable comparative analysis of performance. Many states lack uniform guidelines for reporting. In addition, many nonprofit hospitals lack the infrastructure and competencies to design, implement, and monitor community benefit activities.

A central question of this study is to what extent community benefit principles can assist policy efforts to enhance diversity in health professions. Though community benefit principles offer an attractive framework for holding health professional training programs and their institutional sponsors accountable for advancing goals tied to racial and ethnic diversity of their students and trainees, from a legal perspective, it is important that the principles be applied in the most effective venue. In that regard, while community benefit laws and associated public expectations have evolved out of a tax exemption context, the most practical application of concepts for increased institutional accountability are outside of the tax exemption arena, and are best applied in the accreditation world.

Community benefit principles provide insights for the public expectations of both nonprofit health-care providers and institutions that train these providers. Just as nonprofit hospitals are expected to play a role in addressing priority unmet needs in local communities, HPEIs can appropriately be expected to play a direct role in responding to priority unmet health needs at the local and/or societal level. Furthermore, for publicly sponsored colleges and universities, community benefit concepts might also link governmental subsidies for these public institutions of higher education to performance measures related to student and trainee diversity goals. Community benefit principles should therefore form a conceptual cornerstone by which health professions education accreditation organizations and state governments can set expectations for the advancement of societal goals tied to racial and ethnic diversity of the health-care workforce.

Recommendation 6-1: HPEI governing bodies should develop institutional objectives consistent with community benefit principles that support the goal of increasing health-care workforce diversity including, but not limited to efforts to ease financial and non-financial

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obstacles to URM participation, increase involvement of diverse local stakeholders in key decision-making processes, and undertake initiatives that are responsive to local, regional and societal imperatives (see Recommendation 5-4).

Recommendation 6-2: Health professions accreditation institutions should explore the development of new standards that acknowledge and reinforce efforts by health professions education institutions to implement community benefit principles as they relate to increasing health care workforce diversity.

Recommendation 6-3: HPEIs should develop a mechanism to inform the public of progress toward and outcomes of efforts to provide equal health care to minorities, reduce health disparities, and increase the diversity of the health-care workforce.

Recommendation 6-4: Private and public (e.g., federal, state, and local governments) entities should convene major community benefit stakeholders (e.g., community advocates, academic institutions, health-care providers), to inform them about community benefit standards, and to build awareness that placing a priority on diversity and cultural competency programs is a societal expectation of all institutions that receive any form of public funding.

Mechanisms to Garner Support for Diversity Efforts

Several mechanisms offer promise to increase the general public and key stakeholders' understanding of the need for and benefits of greater diversity among health professionals. This kind of understanding is necessary in order to effectively develop and implement institutional and policy-level strategies to increase diversity among health professionals. Implementation of these strategies should begin with efforts to collect data and conduct additional research to assess diversity among health professionals and in health professions education, and to further identify the benefits of diversity for health care service delivery. Educational initiatives should begin with health professionals, HPEIs, and the communities that they serve. Other stakeholders—including business and corporate leaders, community and grassroots groups, organized labor, policy makers, and elected representatives, among many others—should also be involved in diversity efforts, specifically by forming broad coalitions to advocate for policies to enhance diversity. Several innovative examples of such efforts are underway nationwide, and should be expanded.

Recommendation 7-1: Additional data collection and research is needed to more thoroughly characterize URM participation in the health professions and in health professions education, and to further assess the benefits of diversity among health professionals, particularly with regard to the potential economic benefits of diversity.

Recommendation 7-2: Local and national efforts must be undertaken to increase broad stakeholders' understanding of and consensus regarding steps that should be taken to enhance diversity among health professionals.

Recommendation 7-3: Broad coalitions should advocate to vigorously encourage HPEIs, their accreditation bodies, and federal and state sources of health professions student financial aid to adopt policies to enhance diversity among health professionals.

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Text Box ES-1: Summary of Recommendations

IMPROVING ADMISSIONS POLICIES AND PRACTICES. HPEIs should:

- Develop, disseminate, and utilize a clear statement of mission that recognizes the value of diversity;
- Establish explicit policies regarding the value and importance of culturally competent care, and the role of institutional diversity in achieving this goal;
- Base admissions decisions on a comprehensive review of each applicant, and balance the consideration of quantitative and qualitative data; and,
- Include voting representation from underrepresented groups on admissions committees and provide special incentives to faculty for participation.

REDUCING FINANCIAL BARRIERS TO HEALTH PROFESSIONS TRAINING

- HRSA's health professions training programs should be evaluated to ensure that they maximize URM participation;
- Congress should increase funding for Public Health Service Act Titles VII and VIII programs shown to be effective in increasing diversity;
- Federal and state health agencies should increase support for diversity efforts through programs such as loan forgiveness, tuition reimbursement, loan repayment, Medicaid GME, and supportive affiliations with community-based providers; and,
- Public–private collaboration should be encouraged to support the common goal of developing a more diverse health care workforce.

ENCOURAGING DIVERSITY EFFORTS THROUGH ACCREDITATION. Accreditation bodies should:

- Formulate and enforce diversity-related standards;
- Develop explicit policies articulating the value and importance of culturally competent health care, and the role for racial and ethnic diversity in achieving this goal;
- Develop standards and criteria that encourage and support URM student and faculty participation;
- Include criteria and standards to assess the success of diversity efforts;
- Include URMs and other individuals with expertise in cultural competence and diversity on accreditation bodies and advisory groups; and,
- Apply sanctions if diversity-related standards are not met.

IMPROVING THE INSTITUTIONAL CLIMATE FOR DIVERSITY. HPEIs should:

- Develop and regularly evaluate comprehensive strategies to improve the institutional climate for diversity;
- Proactively and regularly engage and train students, house staff, and faculty regarding institutional diversity-related policies and expectations and the importance of diversity;
- Establish an informal, confidential mediation process for students and faculty who experience barriers to institutional diversity goals; and,
- Affiliate with community-based health-care facilities in order to attract and train a more diverse and culturally competent workforce and to increase access to health care.

APPLYING COMMUNITY BENEFIT PRINCIPLES TO DIVERSITY EFFORTS. HPEIs and relevant public and private groups should:

- Develop institutional objectives consistent with community benefit principles that support the goal of increasing health-care workforce diversity, and reinforce these efforts through program accreditation;
- Explore the development of new standards that acknowledge and reinforce efforts to implement community benefit principles as they relate to increasing health care workforce diversity;
- Develop a mechanism to inform the public of progress toward diversity efforts; and,
- Convene major community benefit stakeholders to inform them about community benefit standards and their relationship to diversity.

MECHANISMS TO ENCOURAGE SUPPORT FOR DIVERSITY EFFORTS include:

- Additional research and data collection on diversity and its benefits;
- Efforts to increase broad stakeholders' understanding of and consensus regarding steps that should be taken to enhance diversity among health professionals; and,
- The development of broad coalitions to encourage HPEIs, their accreditation bodies, and federal and state sources of health professions student financial aid to adopt policies to enhance diversity among health professionals.

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